

## What Is an Interrupted Stay?

An interrupted stay occurs when a Long-Term Care Hospital (LTCH) patient is discharged from an LTCH and after a specific number of days away from the LTCH, is readmitted to the same LTCH for further medical treatment. The original interrupted stay policy, established at the start of the LTCH Prospective Payment System (PPS), for cost reporting periods beginning on or after October 1, 2002, addressed a situation where a patient discharged from an LTCH is directly admitted to a specific type of Medicare provider [an inpatient acute care hospital, an Inpatient Rehabilitation Facility (IRF), or a Skilled Nursing Facility (SNF)/swing bed], then returns to the original LTCH within a specified period of time. This specified period of time, also called a fixed-day period, varies depending on the type of facility that receives the patient from the LTCH.

## Are There Different Types of Interrupted Stays?

In the May 7, 2004 Final Rule for the LTCH PPS, the Centers for Medicare & Medicaid Services (CMS) revised the interrupted stay policy to include a discharge and readmission to the LTCH within 3 days, regardless of where the patient goes upon discharge. With this revision, there are now two components to the interrupted stay policy: the original policy (now called the "greater than 3-day interruption of stay") and the expansion of this policy (the "3-day or less interruption of stay"), effective on July 1, 2004. If a stay falls within either definition, Medicare will pay only one Long-Term Care-Diagnosis Related Group (LTC-DRG) payment to the LTCH.

## What Is the "3-day or Less Interruption of Stay" Policy?

This policy covers LTCH discharges and readmissions to the same LTCH within 3 days. During that time, the patient may have received outpatient or inpatient tests,



<i>Background</i>	<i>What Are Long-Term Care-Diagnosis Related Groups?</i>
<p>Under the Medicare system, Long-Term Care Hospitals (LTCHs) generally treat patients who require hospital-level care for an average of greater than 25 days. The Balanced Budget Refinement Act of 1999 (BBRA) mandated a new discharge-based prospective payment system for LTCHs. The new payment system, the Long-Term Care Hospital Prospective Payment System (LTCH PPS), replaces the current cost-based system. Congress provided further requirements for the LTCH PPS in the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvements and Protection Act of 2000 (BIPA).</p>	<p>The LTCH PPS uses Long-Term Care-Diagnosis Related Groups (LTC-DRGs) as a patient classification system. Each patient stay is grouped into an LTC-DRG based on diagnoses (including secondary diagnoses), procedures performed, age, gender, and discharge status. Each LTC-DRG has a pre-determined Average Length of Stay (ALOS), or the typical Length of Stay (LOS) for a patient classified to the LTC-DRG. Under the LTCH PPS, an LTCH receives payment for each Medicare patient, based on the LTC-DRG to which that patient's stay is grouped. This grouping reflects the typical resources used for treating such a patient. Cases assigned to an LTC-DRG are paid according to the Federal payment rate, including adjustments. One type of case-level adjustment is an interrupted stay.</p>

treatment, or care at an acute care hospital, an IRF, or a SNF/swing bed, or there may have been an intervening patient-stay at home for up to 3 days without the delivery of additional tests, treatment, or care.

If the interruption exceeds 3 days, LTCH payment will be determined under the original interrupted stay policy (now referred to as a "greater than 3-day interruption of stay") but the day count for purposes of determining the length of the stay away from the LTCH begins on the day that the patient is first discharged from the LTCH. Medicare payment for any test, procedure, or care provided to the patient on either an outpatient or inpatient basis during the "interruption" would be the responsibility of the LTCH "under arrangements". This policy is discussed in greater detail in the rest of this Fact Sheet.

## What is the "Greater than 3-day Interruption of Stay" Policy?

If a patient who has been discharged from a LTCH and admitted to an acute care hospital, an IRF, or a SNF/swing bed, is readmitted to the same LTCH after 3 days, the original interrupted stay policy (now called the "greater than 3-day interruption of stay" policy) governs. The following table lists the fixed-day periods for each type of facility:

Facility Type	Fixed-Day Period
Inpatient Acute Care Hospital	Between 4 and 9 days
Inpatient Rehabilitation Facility	Between 4 and 27 days
Skilled Nursing Facility/Swing Bed	Between 4 and 45 days

To meet the full definition of a "greater than 3-day interruption of stay", the patient must also be:

§ Discharged directly from the LTCH and admitted directly to an inpatient acute care hospital, an IRF, or a SNF/swing bed.

AND

§ Discharged back to the original LTCH after a Length of Stay (LOS) less than or equal to the applicable fixed-day period.

If the patient's hospitalization at an acute care hospital, an IRF, or a SNF/swing bed falls respectively within the 9, 27, or 45 day threshold, when the patient is readmitted to the LTCH, the entire stay is considered an interrupted stay and one LTC-DRG payment will be made based on the initial admission. The day count to determine whether or not a patient has been away from the LTCH for purposes of the "greater than 3-day interruption of stay" policy begins on the day of discharge and continues until the day of readmission, even though this policy governs beginning on the patient's fourth day away from the LTCH. A case may have multiple interrupted stays, but each stay must be evaluated separately to make certain that it meets the interrupted stay criteria. Cases with interrupted stays may also be eligible for other case-level adjustments (for example, the case may also be eligible for a short-stay outlier payment).

**As under the original interrupted stay policy, Medicare will make a separate payment to the intervening provider (i.e., the acute care hospital, the IRF, or the SNF/swing bed), if the interruption in the LTCH stay exceeds 3 days and the patient stay is governed by the greater than 3-day interruption of stay policy. Similarly, if the interruption in**

**the LTCH stay exceeds the fixed-day thresholds, the readmission to the LTCH will be treated as a separate LTCH stay and Medicare will make an additional payment to the LTCH when the patient is discharged from the LTCH.**

## What Are Some Examples of Cases Governed Under the 3-day or Less Policy?

The following examples describe scenarios that would be governed under the "3-day or less interruption of stay" policy:

### Example 1:

An LTCH patient is discharged from a LTCH on a Monday (Day 1) and is immediately admitted to an acute care hospital. On Tuesday (Day 2), the patient is released from the acute care hospital and returns home. On Wednesday (Day 3), the patient is readmitted to the LTCH. The patient is discharged from the LTCH four weeks later. In this case, Medicare will pay for the entire stay, including the interruption, with one LTC-DRG payment, which will be determined based upon the patient's entire medical record, including diagnoses and treatment during the intervening hospitalization at the acute care hospital on Day 2 of the interruption. The LTCH will be responsible for paying the acute care hospital for the patient stay on Day 2 "under arrangements".

### Example 2:

An LTCH patient is discharged home on Monday (Day 1). On Tuesday (Day 2), the patient receives outpatient diagnostic tests at an acute care hospital. On Wednesday (Day 3), the patient is readmitted to the LTCH and remains an additional 10 days. In this case, one Medicare payment will be made to the LTCH (and depending upon the entire LOS, it could be a short stay outlier payment), and the LTCH will be responsible for paying the outpatient services received on Day 2 during the interruption.

### Example 3:

An LTCH patient is discharged on July 7, 2004, to an acute care hospital for an appendectomy and returns to the LTCH the next day for a resumption

of the original treatment as well as post-operative care with a discharge occurring 30 days later. In this case, although Medicare will pay only one LTC-DRG payment to the LTCH, payment will be made to the acute care hospital since the appendectomy will be grouped to a surgical DRG. Please see the section of this Fact Sheet titled, How Is Payment made for Services Rendered During an "Interruption"? for more information on the policy for surgical DRG payments.

If in any one of these cases, the patient remained away from the LTCH for more than 3 days, Medicare payment will be made under the original or "greater than 3-day interruption of stay" policy.

### What Is Not an Interrupted Stay?

The following examples are not interrupted stays under the "greater than 3-day interrupted stay" policy:

- § The patient has a LOS at the receiving facility (an acute care inpatient hospital, an IRF, or a SNF/swing bed) that exceeds the fixed-day period for the facility type.

#### Example:

A patient is discharged from the LTCH and then is admitted to an acute care hospital. The patient then returns to the same LTCH after 10 or more days. The return to the LTCH is a new admission.

- § The patient is discharged to a type of facility other than the four types of facilities previously mentioned.

#### Example:

A patient is discharged from the LTCH and then is admitted to care provided by a home healthcare agency. The return to the LTCH is a new admission.

- § The patient is discharged to more than one facility.

#### Example:

A patient is discharged from the LTCH, is admitted to an IRF, and then is discharged from the IRF to an acute care hospital. Finally, the acute care hospital discharges the patient to the original LTCH. The return to the LTCH is a new admission.

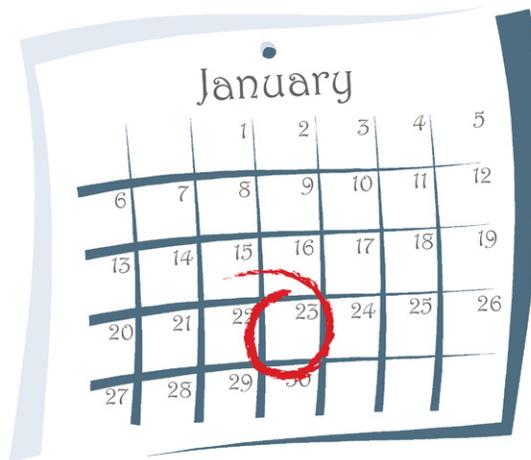
- § The patient returns home between LTCH stays for more than three days.

In all of these scenarios, if a stay disruption does not meet the definition for an interrupted stay, the original discharge ends

the patient's stay. If the patient is readmitted to the facility, the second admission begins a new stay. The LTCH would receive two LTC-DRG payments for two patient stays: one payment for the first stay, and a separate payment for the stay after the readmission to the LTCH.

If the patient's stay meets the interrupted stay criteria, the principal diagnosis should not be changed when the patient returns to the LTCH from the receiving facility. If other medical conditions are apparent upon the patient's return to the LTCH, the additional diagnosis codes should be noted on the claim.

There are no current separate policy provisions regarding transfers between LTCHs. The admissions to each LTCH are treated as separate cases. CMS will be monitoring such discharges.



### How Are Days Counted Under the Interrupted Stay Policy?

The interrupted stay day count begins on the day of discharge from the LTCH and continues until the 9<sup>th</sup>, 27<sup>th</sup>, or 45<sup>th</sup> day after the discharge (depending on the facility type). Though the "greater than 3-day interruption of stay" policy governs from the fourth day forward, the day count of the interruption begins on the first day that patient is away from the LTCH. If an interruption in the patient's stay at an LTCH meets the interrupted stay criteria, the days prior to the original discharge from the LTCH will be added to the number of days following the readmission at the receiving Medicare provider. The days before and after an

interrupted stay determine the total LOS for the episode of care. If the patient is discharged home and returns to the LTCH within 3 days without having received and additional medical treatment, all the days away from the LTCH will not be included in the total LOS. However, if treatment is received on any of the 3 days (for which the LTCH is responsible for "under arrangements"), all the days of the stay should be counted in the total LOS for that patient.

An example of how days are counted under the Interrupted Stay policy is shown below:

A patient is admitted to a LTCH on November 1, 2004 and discharged to an acute care hospital on November 8, 2004. The patient returns to the LTCH on November 14, 2004. Since the time between the discharge to the acute care hospital and the return to the LTCH is 7 days, the stay meets the fixed-day period requirement for acute care hospitals. This example is an interrupted stay case for the LTCH. The first 8 days of the LTCH stay (November 1, 2004 through November 8, 2004) will be added to the day count of the second portion of the LTCH stay. Depending on the accumulated LOS, the LTCH will receive either a short-stay outlier payment or a full LTC-DRG payment for the case.

### How Is Payment Made for Services Rendered During a 3-day or Less "Interruption"?

Medicare payments for any test, procedure, or care provided to an LTCH patient on an outpatient basis or for any inpatient treatment during the "interruption" would be the responsibility of the LTCH "under arrangements". There is one limited exception: from July 1, 2004, through June 30, 2005, if treatment at an inpatient acute care hospital would be grouped to a surgical DRG, a separate Medicare payment would be made under the IPPS for that care. Please refer to Table 5A of the August 1, 2003 IPPS Final Rule to determine whether a DRG is classified as a medical or surgical DRG during FY 2004.

**Therefore, any tests or procedures that were administered to the patient during that period of time, other than inpatient surgical care at an acute care hospital, will be considered part of that single episode of LTCH care and bundled into the payment to the LTCH. The LTCH will be required to pay any other providers without additional Medicare program payment liability. If any tests or procedures are delivered any time during the 3-day interruption (with payment being made by the LTCH to the intervening provider "under arrangements"), all days of the interruption will be included in the total day count for that patient. If no care is provided during the interruption, the days away from the LTCH are not included in the patient stay.**

### How Are Interrupted Stay Payments Determined?

Unlike other case-level adjustments, billing instructions determine payment for interrupted stays. Interrupted stay payments (based on the co-location policy discussed in the next section) are determined by the Fiscal Intermediary at the cost report settlement.

#### *LTCH PPS Final Rules*

CMS published four Final Rules affecting Medicare payments to LTCHs on the following dates:

**August 30, 2002** - the first LTCH PPS Final Rule was published, formalizing the policies and procedures for the new LTCH PPS.

**June 6, 2003** - the first update of the LTCH PPS Final Rule was published, changing the update cycle for future LTCH PPS updates, and revising several payment rates for the LTCH PPS, including the fixed-loss amount.

**June 9, 2003** - the Outlier Final Rule was published, affecting payment calculations for outlier cases. This Final Rule provided several changes to the application of the Cost-to-Charge Ratio (CCR), as well as changes to outlier payment reconciliation policies.

**May 7, 2004** - the FY 2005 Final Rule was published, increasing the Medicare payment rates for LTCHs by 3.1% for FY 2005 starting on July 1, 2004. The Final Rule also further expands the existing interrupted stay policy, finalizes the requirements for a satellite or remote location to qualify as an LTCH, and changes the ALOS calculation for LTCH status.

## Are There Any Special Policies for Co-Located Providers?

If a LTCH is onsite (co-located) with another Medicare provider (for example, a hospital-within-a-hospital or a satellite facility located within another provider), a special interrupted stay payment policy may apply to LTCH patient discharges between the co-located facilities. CMS created this special payment policy to discourage unnecessary patient shifting between providers that share a physical location. Under the policy, if the number of discharges and readmissions between an LTCH and a co-located provider exceeds 5% of the total discharges during a cost reporting period, only one LTC-DRG payment will be payable to the LTCH for all such discharges and readmissions. This payment policy applies to discharges before and after the threshold is exceeded. There are two distinct 5% thresholds, as shown in the following tables:

<i>Co-Located Provider Policy For Onsite Acute Care Hospitals</i>	
<i>If...</i>	<i>Then...</i>
<i>During a cost reporting period, an LTCH readmits more than 5% of its patients who were discharged to an onsite acute care hospital. . .</i>	<i>The LTCH receives only one LTC-DRG payment for all such discharges during the cost reporting period once the 5% threshold is met. This includes all cases prior to, and after, the threshold has been surpassed for that cost reporting period.</i>
<i>Co-Located Provider Policy For Onsite IRF, SNF/Swing Bed, or Psychiatric Facilities</i>	
<i>If...</i>	<i>Then...</i>
<i>During a cost reporting period, an LTCH readmits more than 5% of its patients who were discharged to an onsite IRF, a SNF/ swing bed, or a psychiatric facility (or any combination of the above). . .</i>	<i>The LTCH receives only one LTC-DRG payment for all such discharges during the cost reporting period once the 5% threshold is met. This includes all cases prior to, and after, the threshold has been surpassed for that cost reporting period.</i>

Providers must inform their Fiscal Intermediary and their CMS Regional Office about any co-located facilities within 60 days of the start of the LTCH's first cost reporting period beginning on or after October 1, 2002, or within 60 days of any change in co-location status.

## What Are the Requirements for Satellite or Remote Locations to Qualify as an LTCH?

In the May 7, 2004 Final Rule, CMS finalized its clarification of the requirements for a satellite or remote location to qualify as a LTCH. Generally, where an LTCH is separating from a parent LTCH, the facility must first be separately certified as a hospital (e.g., an acute care hospital) and then present the hospital's discharge data collected after it was separately certified to show that it has met the Average Length of Stay (ALOS) requirement for 5 of the 6 months following certification. If the separation is required by the provider-based regulations, the hospital may submit ALOS data for the satellite or remote location from the 6-month period preceding the separation.

## Where Can I Find More Information about the LTCH PPS?

The following online references provide more information about the LTCH PPS:

- § The Medicare Learning Network LTCH PPS Web Page

[www.cms.hhs.gov/medlearn/ltchpps.asp](http://www.cms.hhs.gov/medlearn/ltchpps.asp)

The Medicare Learning Network features CMS provider education materials for the LTCH PPS, including the *CMS Long-Term Care Hospital Prospective Payment System Training Guide*.

§ Long-Term Care Hospital Web Page

[www.cms.hhs.gov/providers/longterm/default.asp](http://www.cms.hhs.gov/providers/longterm/default.asp)

The Long-Term Care Hospital Web Page provides the Final Rules and additional LTCH PPS-related documents, including a Frequently Asked Questions (FAQs) List. The website also provides instructions on joining the LTCH PPS mailing list, which provides the latest LTCH PPS news and updates.

§ LTCH PPS Press Release updating the LTCH Payment System for Rate Year 2005

[www.cms.hhs.gov/media/press/release.asp?Counter=1028](http://www.cms.hhs.gov/media/press/release.asp?Counter=1028)

The press release summarizes how Medicare is updating the format and data of the LTCH PPS for Rate Year 2005. These changes were also published in the Federal Register on May 7, 2004.

§ Final Rule on Annual Payment Rate Updates and Policy Changes

[www.cms.hhs.gov/providers/longterm/cms-1263-f.pdf](http://www.cms.hhs.gov/providers/longterm/cms-1263-f.pdf)

The Final Rule provides a more in-depth look at the changes for Rate Year 2005.

§ Federal Register Notice for LTCH PPS FY 2005 Proposed Rule (CMS-1428-P)

[www.cms.hhs.gov/providers/longterm/frnotices.asp](http://www.cms.hhs.gov/providers/longterm/frnotices.asp)

The Proposed Rule contains the proposed LTC-DRGs, relative weights, ALOS, and other proposed Inpatient Prospective Payment System (IPPS)-excluded hospital policy changes that would be effective October 1, 2004, under the LTCH PPS.

Questions about interrupted stays and the LTCH PPS can be emailed to [ltchpps@cms.hhs.gov](mailto:ltchpps@cms.hhs.gov).

## Where Can I Find More Information about ICD-9-CM Coding?

The LTCH PPS Final Rule emphasized that proper coding is essential for correct diagnosis and procedure reporting. The following online references provide ICD-9-CM coding guidance:

§ The ICD-9-CM Official Guidelines for Coding and Reporting

[www.cdc.gov/nchs/data/icd9/icdguide.pdf](http://www.cdc.gov/nchs/data/icd9/icdguide.pdf)

The LTCH PPS Final Rule stated that the *ICD-9-CM Official Guidelines for Coding and Reporting* is essential reading for understanding how to report the proper diagnosis and procedure codes that are used in determining the LTC-DRG payment amounts.

§ Updates to the ICD-9-CM Diagnosis and Procedure Codes

[www.cms.hhs.gov/paymentsystems/icd9/default.asp](http://www.cms.hhs.gov/paymentsystems/icd9/default.asp)

This website identifies the activities (including public meeting schedules and agendas) of the ICD-9-CM Coordination and Maintenance Committee charged with maintaining and updating the ICD-9-CM coding system.